

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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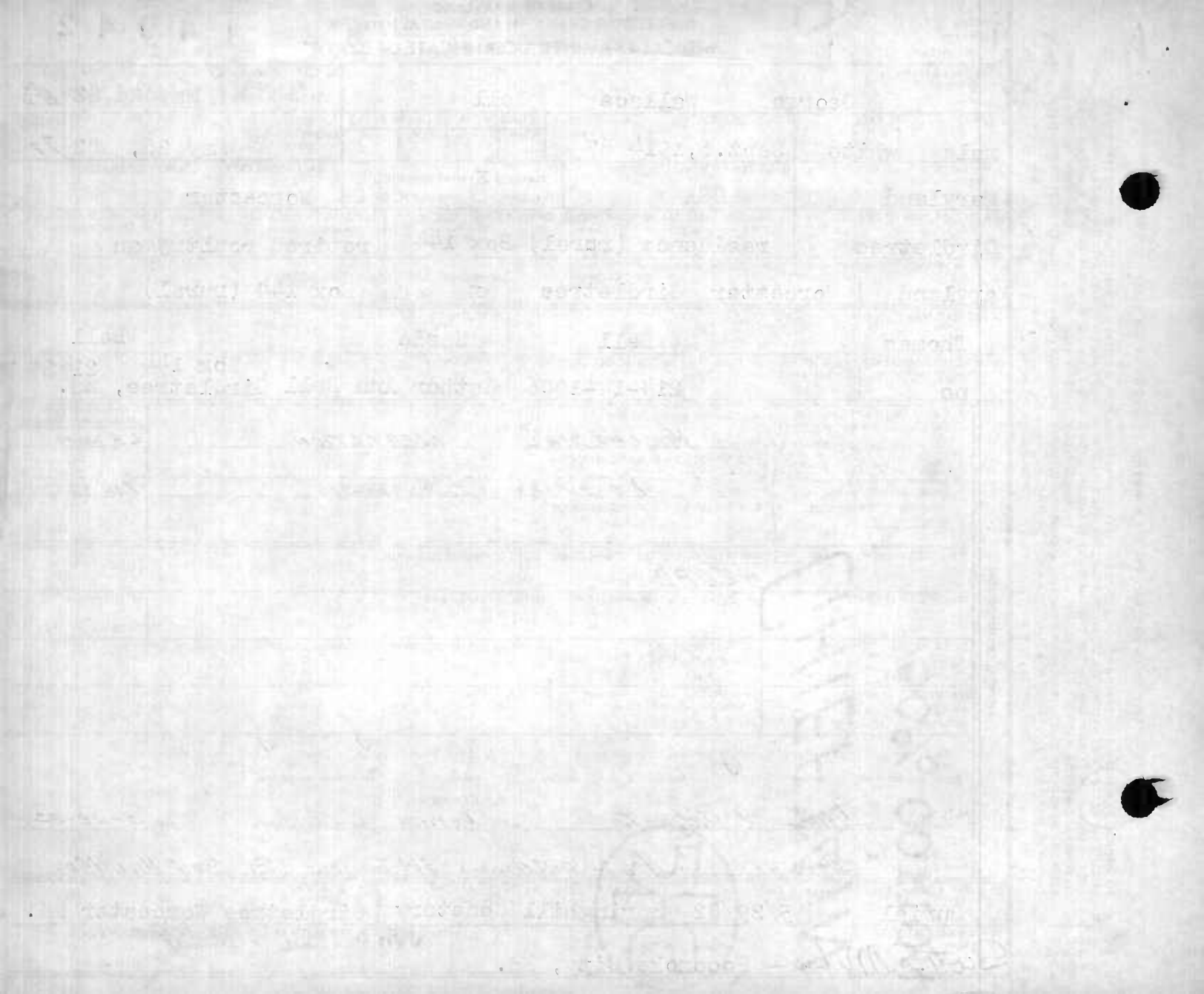
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

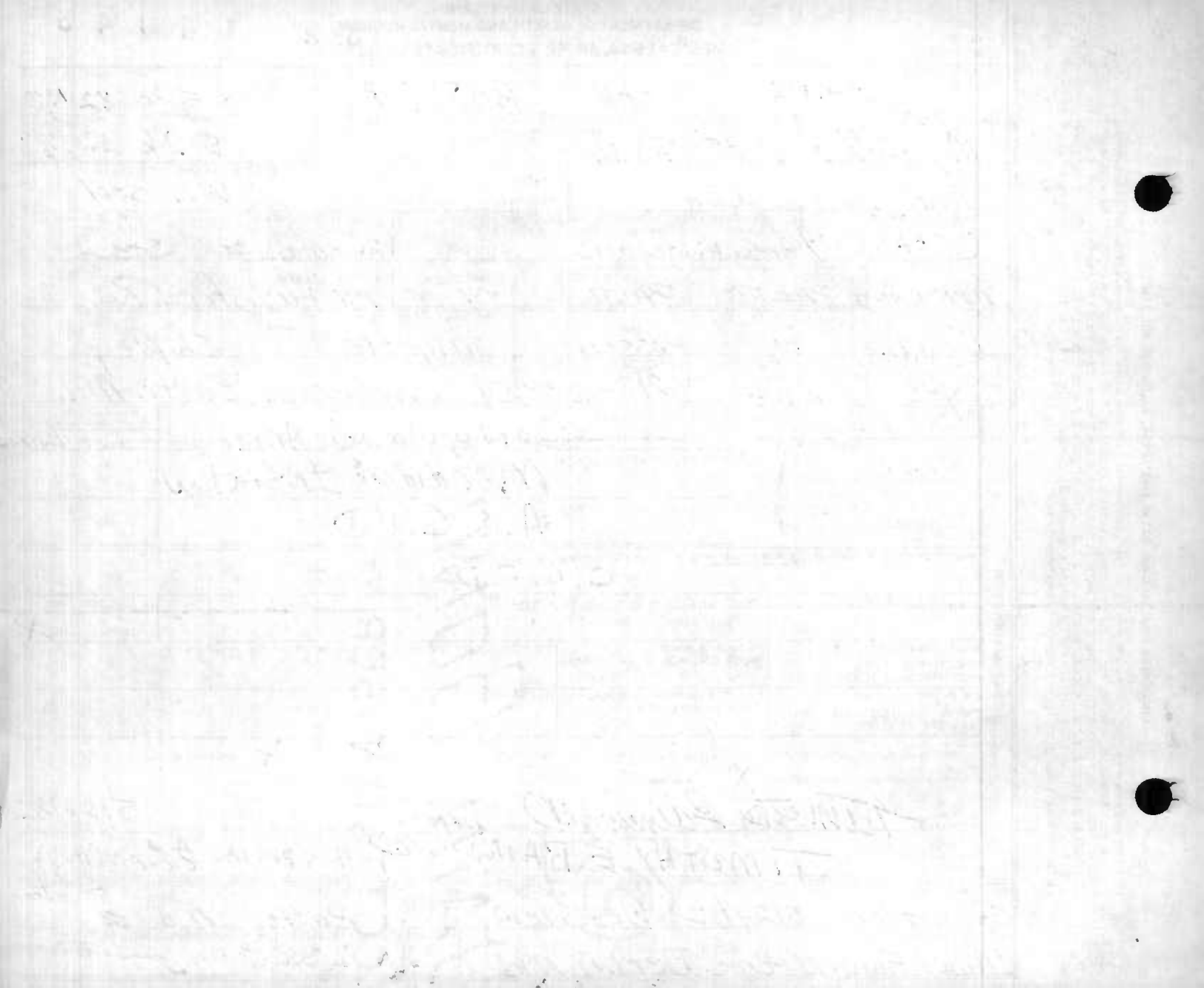
14042

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
George Wallace Bell						May 26, 1982						6:50 PM
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
male	white	Sept. 6, 1914	67 YRS.			May 26, 1982						7 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		USA				Worcester						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Girdletree			residence (rural) Box 144			retired poultryman						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
Maryland			Worcester		Girdletree	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Box 144 (rural)					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST			FIRST MIDDLE LAST									
Thomas Bell			Essie Bell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
no			214-14-1006		Esther Ann Bell			Box 144 21829 Girdletree, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION												
DUE TO, OR AS A CONSEQUENCE OF												
(b) CORONARY THROMBOSIS												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
45 MIN												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
COPD												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR									
			P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION						
						STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
TITLE (SPECIFY)												
ACTUAL SIGNATURE			M.D.			MEDICAL EXAMINER			DATE SIGNED			
Dorothy C. Holzworth			DEPUTY						5-28-82			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS									
DOROTHY C. HOLZWORTH			309 TIMMONS ST. SNOW HILL, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial			5/29/82		Springhill Cemetery		Girdletree Worcester Md.					
24. FUNERAL DIRECTOR			25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
NAME ADDRESS			JUN 6 1982									
Scott S. Mulson			Pocomoke City, Md.									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14043	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WAITER JOHN BOSSOM										2a. DATE OF DEATH MONTH DAY YEAR 5 26 1982	
3. SEX M 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR 5-30-15 6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.										2b. DATE OF DEATH ESTIMATED MONTH DAY YEAR 5 26 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH OCEAN CITY 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Green Ridge Lane 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman-Steel 12b. KIND OF BUSINESS OR INDUSTRY Steel											
13a. STATE MARYLAND 13b. COUNTY BALTO 13c. CITY OR TOWN BALTO 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1707 Winford Rd											
14. FATHER'S NAME FIRST MIDDLE LAST Haushon W BOSSOM 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Shipley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES 16b. SOCIAL SECURITY NO. 218-10-9854 17. INFORMANT J.V. BOSSOM ADDRESS Balto. Md											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardiopulmonary Arrest (b) DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction (c) DUE TO, OR AS A CONSEQUENCE OF A.S.C.V.D.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) C.O.P.D.											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Timothy E. Bainum M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 5/26/82											
EXAMINER'S NAME (TYPE OR PRINT) TIMOTHY E. BAINUM, MD ADDRESS 16th & Phila. Ocean City, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE 5/29/82 23c. NAME OF CEMETERY OR CREMATORY Westview 23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md											
24. FUNERAL DIRECTOR NAME Ulrich Funeral Home Berlin, Md. ADDRESS										25a. DATE REC'D. BY REGISTRAR JUN 2 1982 25b. REGISTRAR'S SIGNATURE James J. Smith	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
EDWIN		L.		FISHER				5		9	82	2 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE		BLACK		MAY 12 18 18		63		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
BOX IRON		USA				WORCESTER								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
BERLIN		BERLIN NURSING HOME		LUMBERMAN		LABORER								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
MD.		Worcester		SNOW HILL		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		423 COVINGTON ST.						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST				
JOHN		Fisher				SARAH		COLLICK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/>		WW II		204-07-8087		BERLIN NURSING HOME, Rt. 3 BOX 131								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF (b)		21. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4292		Sepsis - LT.I		G.S.C.V.D.										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. PLACE OF INJURY		21e. LOCATION						
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2		P.M. 19		STREET		CITY OR TOWN		COUNTY STATE		
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION		21d. PLACE OF INJURY		21e. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED								
		J. FRANCIS WARREN, M.D.		M.D.		5.10.82								
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22b. ADDRESS												
J. FRANCIS WARREN, M.D.		BERLIN, MD. 21811												
23a. BURIAL, CREMATION, REMOVAL (IF OTHER, PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE				
BURIAL		MAY 15, 1982		Cool Spring		Gladetree		Worcester		MD				
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE										
Jolley Mem. Chapel		MAY 18 1982		J. Francis Warren										

collected from May 1954 to May 1955
at the following localities:
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100. 1000 ft. above sea level

Hamilton

1000 ft. above sea level

1000 ft. above sea level

1000 ft. above sea level

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 1 4 0 4 5	
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
CLARENCE E. FREEH			5-16-1982		12:25A M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
MALE	WHITE	7-19-1900	81 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
New York	U.S.A.			WORCESTER COUNTY MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
BERLIN	BERLIN NURSING HOME		Handyman			
13a STATE		13b COUNTY	13c CITY OR TOWN	13d STREET ADDRESS		
Maryland		Wicomico	Eden	Box 117		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			
(unknown)			(unknown)			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS			
Yes		WW II	418 Ogle Ave., Fruitland, Md. Mrs. Minnie Ennis Campbell, (friend)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5900						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic pyelonephritis						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE				DEGREE		22c DATE SIGNED
J. FRANCIS WARREN, M.D.				M.D.		5/18/82
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS		22f REGISTER'S SIGNATURE
J. FRANCIS WARREN, M.D.				BERLIN NURSING HOME, RT.3, BOX 13, BERLIN, MD.		THOMAS J. KATHEN
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Burial		5/20/82	Maryland Veterans Cem., Beulah, Dor., Md.			
24 FUNERAL DIRECTOR NAME				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, Salisbury, Md.				MAY 20 1982		THOMAS J. KATHEN

James Brown
as a

James Brown
as a

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 4 0 4 6

1. FOR
STATE
REGISTRAR

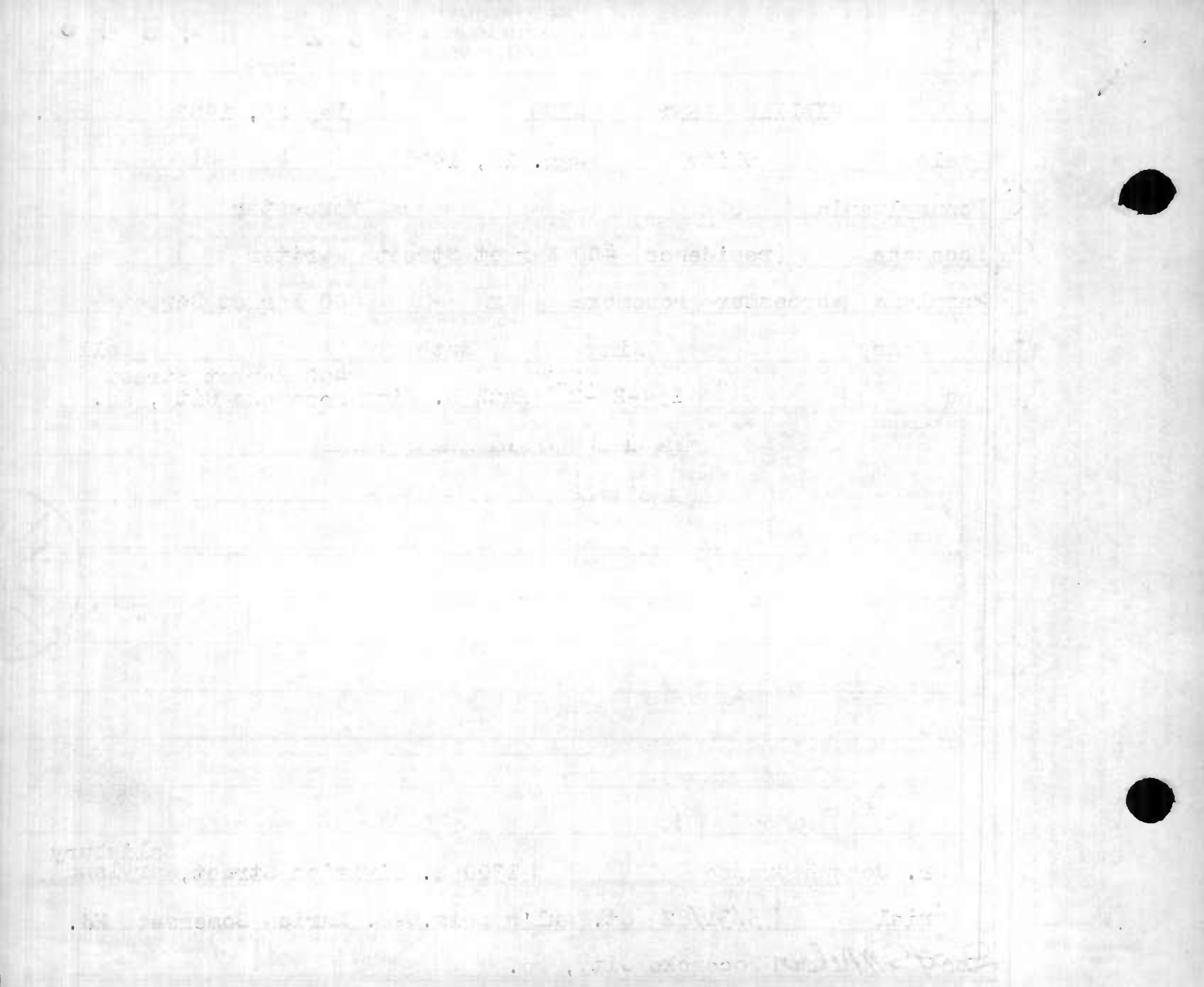
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM KENT KING			2a. DATE OF DEATH MONTH DAY YEAR May 28, 1982		2b. HOUR 6 P.M.						
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan. 17, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.					
10. CITY OR TOWN OF DEATH Pocomoke		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (residence) 400 Market Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) writer		12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 400 Market Street	
14. FATHER'S NAME FIRST MIDDLE LAST Henry King				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Bell				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 154-28-7213	
17. INFORMANT Ruth B. King				ADDRESS 400 Market Street				CITY Pocomoke City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic lung cancer DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Joseph Grasso MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Grasso						22e. ADDRESS 1300 S. Division Street, Salisbury Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/31/82		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Epis. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Marion Somerset Md.			
24. FUNERAL DIRECTOR Scott S. Melson						25a. DATE REC'D. BY REGISTRAR JUN 9 1982					
ADDRESS Pocomoke City, Md.						25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 4 0 4 7

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST SALLIE M. LANDON		2a. DATE OF DEATH MONTH DAY YEAR 5 17-82		2b. HOUR 6:35A _M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9-18-1893		6. AGE (IN YEARS LAST BIRTHDAY) 82 (88) YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER COUNTY MD.			
10. CITY OR TOWN OF DEATH BERLIN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY Somerset		13c. CITY OR TOWN Crisfield		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas G. Landon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Evans		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-10-4490		17. INFORMANT ADDRESS BERLIN, MD. 21811 BERLIN NURSING HOME, RT.3, BOX 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-vascular failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J. Francis Warren</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/17/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. FRANCIS WARREN, M.D.		22e. ADDRESS BERLIN, MD. 21811 BERLIN NURSING HOME, RT.3, BOX 13,							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/20/82		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield-Somerset - MD			
24. FUNERAL DIRECTOR NAME Bradshaw & Sons		ADDRESS Crisfield, MD. 21817		25a. DATE REC'D. BY REGISTRAR MAY 21 1982		25b. REGISTRAR'S SIGNATURE <i>J. Francis Warren</i>			

MEDICAL CERTIFICATION

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James Brown



James Brown

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